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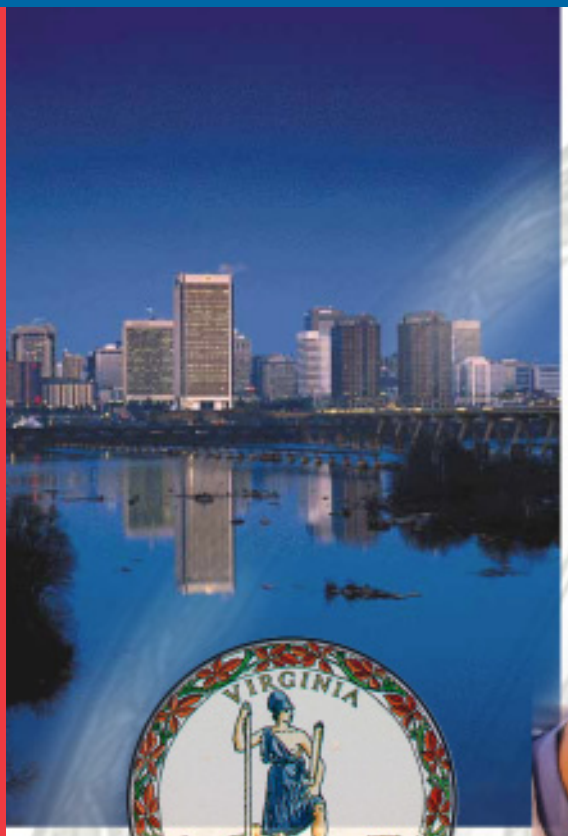

Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

Optima Family Care

SFY 2005

We don't provide healthcare... we make it better.

Section I - Operational Systems Review

Introduction

The operational systems review provides an assessment of the structure, process, and outcomes of the MCO's internal operating systems. The purpose is to identify, validate, quantify, and monitor problem areas in the overall quality assurance program. The review incorporated regulations set forth under the Final Rule of the Balanced Budget Act (BBA) that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and title 42 of the *Code of Federal Regulations* (CFR), part 438 et seq. In support of these regulations and MCO contractual requirements, Delmarva evaluated the following systems:

- Enrollee Rights and Protections—Subpart C Regulation
- Quality Assessment and Performance Improvement—Subpart D Regulation
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Grievance Systems—Subpart F Regulation

It is expected that each MCO will utilize the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

Methodology

The operational systems standards used in the calendar year (CY) 2004 review were the same as those used in the 2003 review period (June through December 2003). These standards incorporate both the BBA and Medallion II contractual requirements. Specifically, in regards to the BBA, these standards include regulations under Subpart C, D, and F of the BBA.

The Operational Systems Review for the period July 2003 through December 2003 was conducted on-site at each MCO. Each element received a compliance rating of "met," "partially met," or "not met." Each element that was not fully met in the 2003 review was assessed as part of the CY 2004 review.

The CY 2004 review of Operational Systems consisted of a desk review of all documents provided by the MCO to assess compliance with all elements that were partially met or not met in the 2003 review. This approach required Delmarva staff to conduct an evaluation of changes to policies, procedures, staff, and processes made by the MCO since the last review. The Delmarva team assessed all documentation provided by the MCO to assess whether or not the MCO had the administrative and operational systems in place and had implemented key operational policies and procedures to meet statutory requirements. During the process, the MCOs were asked to provide additional documentation or clarification where questions or concerns were identified.

As in the 2003 review when Delmarva review staff conducted the review, each element within a standard was rated as "met," "partially met," or "not met". Elements were then rolled up to create a determination of "met", "partially met", or "not met" for each of the standards related to enrollee rights and protections, quality assessment and performance improvement, and grievance system. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Operational Systems Review

Rating	Rating Methodology
Met	All elements within the standard were met
Partially Met	At least half the required elements within the standard were met or partially met
Not Met	Less than half the required elements within the standard were met or partially met

The final element rating was determined as follows. All elements that were met in the 2003 review remained met for the CY 2004 review. All elements that were not fully met (partially met or unmet) were reviewed again and the CY 2004 review determination was applied. Therefore, the Operational Systems Review scores for the CY 2004 should increase from the 2003 year if the MCO made efforts to address the elements that were not fully met in the 2003 review.

Results

The overall performance rating for each of the three major standards is found in Table 2.

Table 2. Operational Systems Review Results by Standard – Calendar Year 2004 Results

Performance Standard	Overall Performance Rating
Subpart C- Enrollee Rights and Protections	Partially Met
Subpart D- Quality Assessment and Performance Improvement	Partially Met
Subpart F- Grievance Systems	Partially Met

A total of 47 standards are evaluated as part of the Operational Systems Review. Of the seven (7) Enrollee Rights standards, four (4) were met and three (3) were partially met. Twenty-seven (27) of the 29 Quality Assessment and Performance Improvement standards were met. Of the 11 Grievance Systems standards eight (8) were fully met and three (3) were partially met. None of the standards received a review determination of not met.

Results for each of the 47 Operational Systems Review elements containing each of the three standards are presented in Table 3. The number of "Met" review determinations is a cumulative sum; it includes the number of elements met in the 2003 review plus those met in the CY 2004 Review.

Table 3. 2004 On-site Operational Systems Review Results for Optima.

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
ER 1	Written policies regarding enrollee rights and protections	10/1/0	Partially Met
ER 2	Information provided to enrollees upon enrollment and according to expected time frames	12/0/0	Met
ER 3	Information and language requirements	7/1/0	Partially Met
ER 4	Protected health information	3/0/0	Met
ER 5	Emergency and post-stabilization services	4/1/0	Partially Met
ER 6	Advanced directives	5/0/0	Met
ER 7	Rehabilitation Act, ADA	2/1/0	Partially Met
QA 1	Availability of services: network of appropriate providers	2/0/0	Met
QA 2	Availability of services: direct access to women's health specialist	1/0/0	Met
QA 3	Availability of services: second opinion	1/0/0	Met
QA 4	Availability of services: out of network	1/0/0	Met
QA 5	Cultural considerations	1/0/0	Met
QA 6	Coordination and continuity of care	1/0/0	Met
QA 7	Coordination and continuity of care: additional services for enrollees with special health care needs	1/0/0	Met

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
QA 8	Direct access to specialists	2/0/0	Met
QA 9	Referrals and treatment plans	1/0/0	Met
QA 10	Primary care and coordination program	3/0/0	Met
QA 11	Coverage and authorization of services: processing of requests	7/1/1	Partially Met
QA 12	Coverage and authorization of services: notice of adverse action	1/0/0	Met
QA 13	Time frame for decisions: standard authorization decisions	1/0/0	Met
QA 14	Time frame for decisions: expedited authorization decisions	1/0/1	Partially Met
QA 15	Provider selection: credentialing and recredentialing requirements	3/0/0	Met
QA 16	Provider selection: non-discrimination	1/0/0	Met
QA 17	Provider discrimination prohibited	1/0/0	Met
QA 18	Provider selection: excluded providers	1/0/0	Met
QA 19	Provider enrollment and disenrollment: requested by MCO	1/0/0	Met
QA 20	Provider enrollment and disenrollment: requested by the enrollee	2/0/0	Met
QA 21	Grievance systems	4/0/0	Met
QA 22	Subcontractual relationships and delegation	4/0/0	Met
QA 23	Practice guidelines	4/0/0	Met
QA 24	Dissemination of practice guidelines	1/0/0	Met
QA 25	Application of practice guidelines	1/0/0	Met
QA 26	Quality assessment and performance improvement program	3/0/0	Met
QA 27	Under/over utilization of services	1/0/0	Met
QA 28	Care furnished to enrollees with special health needs	1/0/0	Met
QA 29	Health/management information systems	5/0/0	Met
GS 1	Grievance system	7/1/0	Partially Met
GS 2	Filing requirements: procedures	2/0/0	Met
GS 3	Notice of action	0/1/0	Partially Met
GS 4	Content of notice action	5/1/0	Partially Met
GS 5	Record-keeping and reporting requirements	1/0/0	Met
GS 6	Handling of grievances and appeals: special requirements for appeals	6/0/0	Met
GS 7	Resolution and notification: grievances and appeals—standard resolution	2/0/0	Met
GS 8	Resolution and notification: grievances and appeals—expedited appeals	4/0/0	Met

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
GS 9	Resolution and notification	3/0/0	Met
GS 10	Requirements for state fair hearings	3/0/0	Met
GS 11	Effectuation of reversed appeal resolutions	2/0/0	Met

Scoring for the individual elements can be found in the Recommendations At-A-Glance Matrix in Appendix I-A1, including recommendations for elements that did not achieve full compliance. Detailed findings for each of the 47 review standards by element can be found in Appendix I-A2.

Conclusions and Recommendations

Conclusions

In the overall results Optima achieved a score of fully met for 38 of the standards evaluated as part of the review of Enrollee Rights, Quality Assessment, and Grievances systems. A review determination of partially met was achieved for the remaining nine (9) standards. None of the 47 standards received a review determination of "Not Met" for the CY 2004 review.

A total of 47 standards are evaluated as part of the Operational Systems Review. Of the seven (7) Enrollee Rights standards, four (4) were met and three (3) were partially met. Twenty-seven (27) of the 29 Quality Assessment and Performance Improvement standards were met. Of the 11 Grievance Systems standards eight (8) were fully met and three (3) were partially met. None of the standards received a review determination of not met.

Recommendations

The recommendations below are a summary of those included in the Detailed Findings section of this report (Appendix IA2). Implementation of these recommendations will facilitate full compliance in the next EQRO review as well as serve to strengthen the MCO's program.

- Optima should revise its Interpreter and Translation Services policy to include procedures for informing enrollees about the availability of alternative formats for MCO information with instructions on how to obtain those formats.
- Optima should provide information in either the Provider Directory or the enrollee handbook on where to obtain post-stabilization services.
- Optima will need to provide compliance monitoring policies as well as written documentation of formal compliance audits, findings, and any recommendations or corrective action plans for the review period that demonstrates implementation of these policies throughout the MCO.

- Optima must develop a more formalized process for assessing inter-rater reliability among its physician review staff including minimum thresholds for performance and corrective action if indicated. There should be evidence of formal reporting of results for both physician and non-physician review staff to the appropriate committee on at least an annual basis.
- Optima must provide copies of utilization management plans from each subcontractor to whom Utilization Management (UM) activities are delegated for the review period. There must be evidence that an annual review of each utilization management plan was conducted by the MCO.
- Optima must revise the Services Requiring Authorization and Timeframes for Decision policy to include the extension timeframe for expedited authorizations.
- Optima must provide evidence of an annual review of all subcontractors' grievance and appeals policies and procedures to determine compliance with DMAS requirements as outlined in its contract. If any are determined to be out of compliance, there should be evidence of a successful corrective action plan to bring them into compliance.

Appendix I-A1
Recommendations At-A-Glance

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services					
1.1	Enrollee rights and responsibilities.		X		In order to receive a finding of met in the next review Optima must revise its enrollee rights to include all required rights identified on page 10 of the Medallion II Contract Modification, dated July 1, 2003. Subsequent to the review Optima submitted a revised Member Rights and Responsibility policy that will be assessed for compliance in the next EQRO review.
1.2	Out of area coverage.	X			
1.3	Restrictions on enrollee's freedom of choice among network providers (431.51).	X			
1.4	Referrals to specialty care (422.113c).	X			
1.5	Enrollee notification – termination/change in benefits, services, or service delivery site.	X			
1.6	Procedures that instruct how to contact enrollee services and a description of the department and its functions.	X			
1.7	Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).	X			
1.8	List of non-English speaking languages spoken by which contracted provider.	X			
1.9	Provider-enrollee communications.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
1.10	Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.	X			
1.11	Enrollment/ Disenrollment.	X			
ER2. Upon enrollment and according to expected timeframes, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):					
2.1	Enrollee rights and responsibilities.				Exempt For The CY 2004 Review
2.2	Enrollee identification cards – descriptions, how and when to use cards.	X			
2.3	All benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.	X			
2.4	Procedures for obtaining out-of-area coverage.	X			
2.5	Procedures for restrictions on enrollee's freedom of choice among network providers.	X			
2.6	The MCO's policy on referrals for specialty care.	X			
2.7	Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.				Exempt For The CY 2004 Review
2.8	Procedures on how to contact enrollee services and a description of the functions of enrollee services.	X			
2.9	Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
2.10	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area; include identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.	X			
2.11	Procedures for provider-enrollee communications.	X			
2.12	Procedures for providing information on physician incentive plans for those enrollees who request it.	X			
2.13	Process for enrollment and disenrollment from MCO.	X			
ER3. Information and Language requirements (438.10)					
3.1	MCO written enrollee information is available in the prevalent, non-English languages (see DMAS contract) of its particular service area.	X			
3.2	Enrollee information is written in prose that is readable and easily understood.	X			
3.3	State requires Flesch-Kincaid readability of 40 or below (at or below 12th grade level).	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
3.4	Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program), notices advising LEP persons of the availability of free language assistance."	X			
3.5	MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	X			
3.6	MCO has policies and procedures in place to make interpretation services available and free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those the State identifies as prevalent.	X			
3.7	MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
3.8	MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.		X		Optima should revise its Interpreter and Translation Services policy to include procedures for informing enrollees about the availability of alternative formats for MCO information with instructions on how to obtain those formats. (It is noted that Optima provided language that is to be included in the July 2005 revision of the enrollee handbook. This will be considered at the time of the next review).
ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)					
4.1	MCO has a confidentiality agreement in place with providers who have access to Protected Health Information (PHI).	X			
4.2	The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of PHI.	X			
4.3	The Contractor shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified and in the format requested by the Department.	X			
ER5. Emergency and Post-Stabilization Services (438.114, 422.113c)					
5.1	MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
5.2	MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.	X			
5.3	MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.	X			
5.4	MCO has provided enrollees with a description of how to obtain emergency transportation and other medically necessary transportation. (Medical HelpLine Access).	X			
5.5	MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.			X	Optima should provide information in either the Provider Directory or the enrollee handbook on where to obtain post-stabilization services. (It is noted that Optima submitted revised language to be included in the enrollee handbook and this will be assessed for compliance at the time of the next review.)
ER6. Advanced Directives					
6.1	The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.	X			
6.2	MCO has requirements to allow enrollees to participate in treatment decisions/options.	X			
6.3	Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
6.4	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.	X			
6.5	MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.	X			
ER7. Rehabilitation Act, ADA					
7.1	MCO is in compliance with Federal and State laws regarding enrollee confidentiality.		X		Optima will need to provide compliance monitoring policies as well as written documentation of formal compliance audits, findings, and any recommendations or corrective action plans for the review period that demonstrates implementation of these policies throughout the MCO.
7.2	MCO has provided the enrollee with a description of their confidentiality policies.	X			
7.3	MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
QA1. 438.206 Availability of services (b)					
1.1	MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract as evidenced by the following:	**X**			
1.2	MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.	**X**			
QA2. 438.206 Availability of services (b)(2)					
2.1	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventive care services, as well as a primary care provider.	**X**			
QA3. 438.206 Availability of services (b)(3)					
3.1	MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.	**X**			
QA4. 438.206 Availability of services (b)(4)					
4.1	MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.	**X**			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA5. 438.206(c) (2) Cultural considerations					
5.1	The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.	X			
QA6. 438.208 Coordination and continuity of care					
6.1	MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.	X			
QA7. 438.208(c) 1-3 Coordination and continuity of care – additional services for enrollees with special health care needs					
7.1	The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.	X			
QA8. 438.208(c) (4) Direct Access to specialists					
8.1	The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.	X			
8.2	Referral guidelines that demonstrate the conditions under which PCPs make arrangements for referrals to specialty care networks.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA9. 438.208 (d) (2) (ii – iii) Referrals and Treatment Plans					
9.1	The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.	X			
QA10. 438.208(e) Primary Care and Coordination Program					
10.1	MCO coordinates services furnished to enrollee with those of other MCOs, PHPs, or PAHPs to prevent duplication.	X			
10.2	Coordination of care across settings or transitions in care.	X			
10.3	MCO has policies and procedures to protect enrollee privacy while coordinating care.	X			
QA11. 438.210 (b) Coverage and Authorization of Services - Processing of requests					
11.1	The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.	X			
11.2	MCO has policies and procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventative services, and basic prenatal care.	X			
11.3	The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.		X		Optima must develop a more formalized process for assessing inter-rater reliability among its physician review staff including minimum thresholds for performance and corrective action if indicated. There should be evidence of formal reporting of results for both physician and non-physician review staff to the appropriate committee on at least an annual basis.

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
11.4	The MCO has policies and procedures in place for staff to consult with requesting providers when appropriate.	X			
11.5	If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.	X			
11.6	Subcontractor's Utilization Management (UM) plan is submitted annually and upon revision.			X	Optima must provide copies of utilization management plans from each subcontractor to whom UM activities are delegated for the review period. There must be evidence that an annual review of each utilization management plan was conducted by the MCO.
11.7	The MCO has policies and procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	X			
11.8	MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.	X			
11.9	MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.	X			
QA12. 438.210 (c) Coverage and authorization of services - Notice of adverse action					
12.1	MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA13. 438.210 (d) (1) Timeframe for decisions – Standard Authorization Decisions					
13.1	MCO provides decision notice as expeditiously as enrollee's health condition requires, not to exceed 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.	X			
QA14. 438.210 (d) (2) Timeframe for decisions – Expedited Authorization Decisions					
14.1	The MCO has policies and procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.	X			
14.2	The MCO has policies and procedures relating to the extension time frames for expedited authorizations allowed under the state contract.			X	Optima must revise the Services Requiring Authorization and Timeframes for Decision policy to include the extension timeframe for expedited authorizations. (It is noted that a revised policy was submitted and will be assessed at the time of the next review).
QA15. 438.214 (b) Provider selection - Credentialing and recredentialing requirements					
15.1	The MCO has written policies and procedures for selection and retention of providers.	X			
15.2	MCO recredentialing process takes into consideration the performance indicators obtained through Quality Improvement Projects (QIPs), UM program, Grievances and Appeals, and Enrollee satisfaction surveys.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
15.3	MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.	X			
QA16. 438.214 (c) Provider selection - Nondiscrimination					
16.1	MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	X			
QA17. 438.12 (a, b) Provider discrimination prohibited					
17.1	For those individual or group providers who are declined, the MCO provides written notice with reason for decision.	X			
QA18. 438.214 (d) Provider Selection – Excluded Providers					
18.1	MCO has policies and procedures and adheres to ineligible provider or administrative entities requirements.	X			
QA19. 438.56 (b) Provider Enrollment and Disenrollment – requested by MCO					
19.1	MCO has policies and procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA20. 438.56 (c) Provider Enrollment and Disenrollment – requested by enrollee					
20.1	MCO has policies and procedures in place for enrollees to request disenrollment.	X			
20.2	MCO has policies and procedures and adheres to timeframes established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).	X			
QA21. 438.228 Grievance systems					
21.1	MCO has a process for tracking requests for covered services that were denied.	X			
21.2	MCO has process for fair hearing notification.	X			
21.3	MCO has process for provider notification.	X			
21.4	MCO has process for enrollee notification and adheres to state timeframes.	X			
QA22. 438.230 Subcontractual relationships and delegation					
22.1	MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.	X			
22.2	MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor; and	X			
22.3	MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
22.4	MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.	X			
QA23. 438.236 (a, b) Practice guidelines					
23.1	The MCO has adopted practice guidelines that meet current quality standards and the following:				
a)	Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	X			
b)	Consider the needs of enrollees.	X			
c)	Are adopted in consultation with contracting health care professionals, and	X			
d)	Are reviewed and updated periodically, as appropriate.	X			
QA24. 438.236 (c) Dissemination of Practice Guidelines					
24.1	The MCO has policies and procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	X			
QA25. 438.236 (d) Application of Practice Guidelines					
25.1	MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA26. 438.240 Quality assessment and performance improvement program					
26.1	MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.	X			
26.2	MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.	X			
26.3	The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	X			
QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services					
27.1	MCO's Quality Assurance Process Improvement (QAPI) program has mechanisms to detect both underutilization and over utilization of the MCO services.	X			
QA28. 438.240 (b) (3) Basic elements of QAPI program – care furnished to enrollees with special health needs					
28.1	MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.	X			
QA29. 438.242 Health/Management Information systems					
29.1	The MCO has information systems capable of furnishing timely, accurate, and complete information about the MCO program.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
29.2	The MCO information system is capable of: a. Accepting and processing enrollment. b. Reconciling reports of MCO enrollment/ Eligibility. c. Accepting and processing provider claims and encounter data. d. Tracking provider network composition, access to services, grievances and appeals, e. Performing QI activities.	X			
29.3	Furnishing DMAS with timely, accurate, and complete clinical and administrative information.	X			
29.4	MCO ensures that data submitted by providers is accurate by: a. Verifying the accuracy and timeliness of reported data. b. Screening the data for completeness, logic, and consistency. c. Collecting the service information in standard formats for DMAS. d. Assigns unique identifiers to providers and requires that identifiers are used when providers submit data to the MCO.	X			
29.5	MCO uses encryption processes to send PHI over the internet.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS1. 438.402 (a, b) Grievance System					
1.1	MCO has written policies and procedures that describe the grievance and appeals process and how it operates.	X			
1.2	The definitions for grievances and appeals are consistent with those established by the state 7/03.	X			
1.3	Policies and procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances, and appeals for the MCO program separately from other programs.	X			
1.4	Policies and procedures describe how MCO responds to grievances and appeals in a timely manner.	X			
1.5	Policies and procedures describe the documentation process and actions taken.	X			
1.6	Policies and procedures describe the aggregation and analysis of the data and use in QI.	X			
1.7	The procedures and any changes to the policies must be submitted to the DMAS annually.	X			
1.8	MCO provides information about grievance and appeals system to all providers and subcontractors.		X		Optima must provide evidence of an annual review of all subcontractors' grievance and appeals policies and procedures to determine compliance with DMAS requirements as outlined in its contract. If any are determined to be out of compliance, there should be evidence of a successful corrective action plan to bring them into compliance.

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS2. 438.402 (3) Filing Requirements - Procedures					
2.1	The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.	X			
2.2	The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	X			
GS3. 438.404 Notice of Action					
3.1	Notice of action is written according to language and format requirements set forth in GS 438.10 Information Requirements.		X		The notice of action is written in English, however, there is a sentence included in Spanish that advises enrollees that interpreter service is available in 140 languages but it does not explicitly state how to obtain this assistance. The notice does include a toll-free number for contacting Member Services to begin the appeals process. The notice of action does not contain any language that informs the enrollee that alternative formats are available for those with special needs, such as visual impairments or limited reading proficiency.
S4. 438.404 (b) Content of Notice Action **Content of NOA explains all of the following:**					
4.1	The action taken and reasons for the action.	X			
4.2	The enrollee's right to file an appeal with MCO.	X			
4.3	The enrollee's right to request a State fair hearing.	X			
4.4	The procedures for exercising appeal rights.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
4.5	The circumstances under which expedited resolution is available and how to request an expedited resolution.		X		In order to receive a finding of met in the next EQRO review, Optima needs to add language to the notice of action to describe the circumstances under which an expedited appeal is available. A revised NOA was subsequently submitted and will be assessed for compliance in the next EQRO review.
4.6	The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.	X			
GS5. 438.416 Record Keeping and reporting requirements					
5.1	The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.	X			
GS6. 438.406 Handling of grievances and appeals – special requirements for appeals					
6.1	MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating the enrollee's condition or disease.	X			
6.2	MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
6.3	MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.	X			
6.4	MCO informs enrollee of limited time available for cases of expedited resolution.	X			
6.5	MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.	X			
6.6	MCO continues benefits while appeal or state fair hearing is pending.	X			
GS7. 438.408 Resolution and Notification: Grievances and Appeals – Standard Resolution					
7.1	MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires- not exceeding 30 days from initial date of receipt of the appeal.	X			
7.2	In cases of appeals decisions not being rendered within 30 days, MCO provides written notice to enrollee.	X			
GS8. 438.408 Resolution and Notification: Grievances and Appeals – Expedited Appeals					
8.1	MCO has an expedited appeal process.	X			
8.2	The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three (3) working days from the initial receipt of the appeal.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
8.3	MCO has a process for extension, and for notifying enrollee of reason for delay.	X			
8.4	MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.	X			
GS9. 438.408 (b-d) Resolution and notification					
9.1	MCO decisions on expedited appeals are in writing and include decision and date of decision.	X			
9.2	For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a state fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.	X			
9.3	MCO gives enrollee oral notice of denial and follows up within 2 calendar days with written notice.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS10. 438.408 (c) Requirements for State Fair Hearings					
10.1	MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.	X			
10.2	MCO provides state with a summary describing basis for denial and for appeal.	X			
10.3	MCO faxes appeal summaries to state in expedited appeal cases.	X			
GS11. 438.410 Expedited resolution of appeals, GS. 438.424 Effectuation of reversed appeal resolutions					
11.1	The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or the state fair hearing department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.	X			
11.2	MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.	X			

Subpart C Regulations: Enrollee Rights and Protections

ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services

Element 1.1 - Enrollee rights and responsibilities.
This element is partially met.

The Member Rights and Responsibilities (Optima Family Care Member Rights and Responsibilities) policy, effective May 2005, lists 14 member/patient rights. Missing from this list are the "free exercise of those rights and that exercise of those rights, does not adversely affect the way the Contractor and its providers treat the enrollee" and the right to "request that they (medical records) be amended or corrected" as required by the Medallion II Contract Modification, dated July 1, 2003.

Recommendations:
In order to receive a finding of met in the next review Optima must revise its enrollee rights to include all required rights identified on page 10 of the Medallion II Contract Modification, dated July 1, 2003. Subsequent to the review, Optima submitted a revised Member Rights and Responsibility policy that will be assessed for compliance in the next EQRO review.

Element 1.2 - Out of area coverage.
This element is previously met - not reviewed.

Element 1.3 - Restrictions on enrollee's freedom of choice among network providers (431.51).
This element is previously met - not reviewed.

Element 1.4 - Referrals to specialty care (422.113c).
This element is previously met - not reviewed.

Element 1.5 - Enrollee notification – termination/change in benefits, services or service delivery site.
This element is previously met - not reviewed.

Element 1.6 - Procedures that instruct how to contact enrollee services and a description of department and its functions.
This element is previously met - not reviewed.

Element 1.7 - Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).
This element is previously met - not reviewed.

Element 1.8 - List of non-English languages spoken by contracted providers.
This element is previously met - not reviewed.

Element 1.9 - Provider-enrollee communications.
This element is previously met - not reviewed.

Element 1.10 - Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.
This element is met.

The Insolvency of MCO-Hold Harmless language policy, effective July 2005, states that Optima members will not be held liable for payment in case of MCO insolvency. Procedures include incorporating a prescribed Hold Harmless Clause in each provider contract and the member Evidence of Coverage (EOC) in the Miscellaneous section. The Member Guide Changes for the July 2005 version included hold harmless language to be inserted in the Miscellaneous section under 11.4.

Element 1.11 - Process for enrollment and disenrollment from MCO.
This element is previously met - not reviewed.

ER2. Upon enrollment and according to expected timeframes, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):

Element 2.1 - Enrollee rights and responsibilities.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting Optima in meeting this element in the next review.

As evidence of compliance with this element Optima submitted the Member Guide with Evidence of Coverage dated July 2004 with proposed July 2005 changes. This revised document is scheduled for

submission to the Department of Medical Assistance Services and the Bureau of Insurance in August 2005. In the section entitled "What Are My Rights? is a revision to include language to address the right of freedom from any form of restraint or seclusion. As noted in ER 1.1 above, missing from this list are the "free exercise of those rights and that exercise of those rights does not adversely affect the way the Contractor and its providers treat the enrollee" and the right to "request that they (medical records) be amended or corrected" as required by the Medallion II Contract Modification, dated July 1, 2003.

Recommendations:
In order to receive a finding of met in the next review Optima must revise its enrollee rights to include all required rights identified on page 10 of the Medallion II Contract Modification, dated July 1, 2003.

Element 2.2 - Enrollee identification cards – descriptions and how and when to use cards.
This element is previously met - not reviewed.

Element 2.3 - All benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.
This element is previously met - not reviewed.

Element 2.4 - Procedures for obtaining out-of-area coverage.
This element is previously met - not reviewed.

Element 2.5 - Procedures for restrictions on enrollee's freedom of choice among network providers.
This element is previously met - not reviewed.

Element 2.6 - The MCO's policy on referrals for specialty care.
This element is previously met - not reviewed.

Element 2.7 - Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting Optima in meeting this element in the next review.

A July 2005 draft of the Member Handbook includes a section on Change in Optima Benefits or Services advising enrollees that they will be notified in writing or through an update to the Member Handbook of any changes. Additionally, in the Your Rights section enrollees are advised that they will be notified at least 14 days before there are any program or site changes that affect them. This proposed revision satisfies the requirement of this element.

Element 2.8 - Procedures on how to contact enrollee services and a description of the functions of enrollee services.
This element is previously met - not reviewed.

Element 2.9 - Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
This element is previously met - not reviewed.

Element 2.10 - Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
This element is previously met - not reviewed.

Element 2.11 - Procedures for provider-enrollee communications.
This element is previously met - not reviewed.

Element 2.12 - Procedures for providing information on physician incentive plans for those enrollees who request it.
This element is previously met - not reviewed.

Element 2.13 - Process for enrollment and disenrollment from MCO.
This element is previously met - not reviewed.

ER3. Information and Language requirements (438.10).

Element 3.1 - MCO written enrollee information is available in the prevalent, non-English languages spoken in its particular service area (see DMAS contract).
This element is previously met - not reviewed.

Element 3.2 - Enrollee information is written in prose that is readable and easily understood.
This element is previously met - not reviewed.

Element 3.3 - State requires Flesch-Kincaid readability of 40 or higher (at or below 12th grade level).
This element is previously met - not reviewed.

Element 3.4 - Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents include: "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program), ...notices advising people with limited English proficiency of the availability of free language assistance."
This element is previously met - not reviewed.

Element 3.5 - MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
This element is met.

The Interpreter and Translation Services policy, effective April 2005, details availability of enrollee materials in alternative formats for enrollees who have hearing or visual impairments or speak a non-English language. For enrollees with hearing impairments a closed-captioned enrollee education video is available in addition to sign language interpreters. For enrollees who have vision impairments, audio translation of the enrollee education video is available as well as home visits to assist the enrollee with accessing and understanding Optima benefits. The Member Orientation Guide and enrollee education video are available in Spanish. For translation into other languages, the AT&T Language Line is utilized to explain the benefits to enrollees as needed. Optima has provided language that will be included in the July 2005 revision of the enrollee handbook under the section entitled Who do I call when I have questions or concerns? The proposed language would inform enrollees about the availability of oral translation of enrollee orientation materials as well as a home visit educational session. Enrollees are also advised of the availability of a closed caption enrollee education video for enrollees with hearing impairments. This section includes toll-free phone numbers for contacting Member Services for assistance.

Element 3.6 - MCO has policies and procedures in place to make interpretation services available and free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those the state identifies as prevalent.
This element is previously met - not reviewed.

Element 3.7 - MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.
This element is previously met - not reviewed.

Element 3.8 - MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.
This element is partially met.

The Interpreter and Translation Services policy addresses procedures for providing enrollees with materials in alternative formats; however, there are no procedures that explicitly state how the availability of these alternative formats will be communicated to enrollees including instructions for accessing them. As noted in 3.5, Optima has provided language that is to be included in the July 2005 revision of the enrollee handbook under the section entitled Who do I call when I have questions or concerns? The proposed language would inform enrollees about the availability of alternative formats and toll-free phone numbers for contacting Member Services for assistance.

Recommendation:
Optima should revise the above policy to include procedures for informing enrollees about the availability of alternative formats for MCO information with instructions on how to obtain those formats. Subsequent to the review, Optima submitted a revised Interpreter and Translation Services policy that will be assessed for compliance in the next EQRO review.

ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Element 4.1 - MCO has a confidentiality agreement in place with providers who have access to protected health information (PHI).
This element is previously met - not reviewed.

Element 4.2 - The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of PHI.
This element is previously met - not reviewed.

Element 4.3 - The Contractor shall make an individual's PHI available to the Department within 30 days of an individual's request for such information as notified and in the format requested by the Department.
This element is previously met - not reviewed.

ER5. Emergency and Post-Stabilization Services (438.114, 422.113c).

Element 5.1 - MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.
This element is met.

The Emergency Care and Treatment policy was revised October 2004 to include all required elements. The policy now addresses the use of prudent layperson standards to determine authorization/coverage of care and the procedures explicitly state that emergency situations do not require preauthorization from the health plan or the physician. Additionally, the procedures include a definition of post stabilization services and the waiver of preauthorization for coverage of these services. The Specialists: OFC and Stabilization document provides instruction to claims processors for processing claims for post-stabilization services. The July 2004 revision of the enrollee handbook includes a detailed definition of post-stabilization services in the Covered Benefits section.

Element 5.2 - MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.
This element is previously met - not reviewed.

Element 5.3 - MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
This element is previously met - not reviewed.

Element 5.4 - MCO has provided enrollees with a description of how to obtain emergency transportation and other medical necessary transportation (Medical HelpLine Access).
This element is previously met - not reviewed.

Element 5.5 - MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.
This element is not met.

There was no evidence in the enrollee handbook, revised July 2004, that enrollees have been provided with information on locations that furnish post-stabilization services covered by the MCO. Content relating to post-stabilization services was limited to a definition of these services.

Recommendation:
Optima should add information in either the Provider Directory or the enrollee handbook on where to obtain post-stabilization services. If all hospitals provide emergency and post-stabilization services, a brief statement would be sufficient. If all hospitals do not provide emergency and post-stabilization services, those that do provide such services should be specifically identified. Subsequent to the review, Optima submitted revised language to be included in the member handbook, which will be assessed for compliance in the next EQRO review.

ER6. Advanced Directives.

Element 6.1 - The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.
This element is previously met - not reviewed.

Element 6.2 - MCO has requirements to allow enrollees to participate in treatment decisions/options.
This element is previously met - not reviewed.

Element 6.3 - Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.
This element is previously met - not reviewed.

Element 6.4 - MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is previously met - not reviewed.

Element 6.5 - MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.
This element is previously met - not reviewed.

ER7. Rehabilitation Act, ADA.

Element 7.1 - MCO complies with Federal and State laws regarding enrollee confidentiality.
This element is partially met.

As a result of the 2003 review findings, Optima was required to submit evidence of policies that address how the MCO monitors compliance with federal and state laws regarding enrollee confidentiality as well as written documentation of formal compliance audits, findings, and any recommendations or corrective action plans for the review period that demonstrate implementation of these policies. As evidence of compliance Optima submitted policies that address reporting all violations of any federal or state law or regulation to the appropriate law enforcement or regulatory agency (Policy 910: Voluntary Disclosure of Violations of Federal and State Laws and Regulations in a Timely Manner); employee responsibility for ensuring that the laws or regulations affecting their job responsibilities are being complied with in the performance of their job responsibilities (Policy 905: Employees' Responsibility for Compliance); and call monitoring procedures for customer service representatives for quality assurance (Silent Call Monitoring).

Evidence of completed call monitoring audits was also submitted. Follow-up contact with the Medicaid Program Manager produced an additional policy on Confidentiality, which outlines requirements for protecting patient privacy and an excerpt from a training program for Medical Care Management, which demonstrates annual training on Integrity and Compliance. None of the policies, the training program excerpts, or the call monitoring results fully address the requirements of this element, either individually or in combination.

Recommendations:
In order to receive a finding of met in the next review, Optima will need to furnish compliance monitoring policies as well as written documentation of formal compliance audits, findings, and any recommendations or corrective action plans for the review period that demonstrate implementation of these policies throughout the MCO.

Element 7.2 - MCO has provided the enrollee with a description of their confidentiality policies.
This element is previously met - not reviewed.

Element 7.3 - MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.
This element is previously met - not reviewed.

Subpart D Regulations: Quality Assessment and Performance Improvement

QA1. 438.206 Availability of services (b).

Element 1.1 - MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.
This element is previously met - not reviewed.

Element 1.2 - MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.
This element is met.

The Medical Care Management policy, Members Changing Benefit Plans and Continuity of Care, states that enrollees with chronic disabling conditions or children with special needs may have their specialist coordinate their health care by having an extended referral or in some cases based upon the specialist request that they may act as a PCP. Additionally, Optima has provided proposed language that is planned for inclusion in the July 2005 revision of the enrollee handbook under the section entitled How do I choose or change my family doctor? The proposed language would inform enrollees that if they have a disabling condition, chronic illness, or special health need and requires a specialist PCP to contact Member Services for assistance.

QA2. 438.206 Availability of services (b)(2).

Element 2.1 - MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is previously met - not reviewed.

QA3. 438.206 Availability of services (b)(3).

Element 3.1 - MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.
This element is previously met - not reviewed.

QA4. 438.206 Availability of services (b)(4)

Element 4.1 - MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.
This element is previously met - not reviewed.

QA5. 438.206(c)(2) Cultural considerations.

Element 5.1 - The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.
This element is met.

Optima has several policies that identify resources for assisting non-English speaking enrollees and promoting the delivery of culturally competent services by MCO staff. The Medical Intake Screenings policy includes procedures for documenting language of any non-English speaking enrollee. The Interpreter and Translation Services policy includes available resources for interpreter services in physician and MCO offices for enrollees who speak a language other than English. The Cultural Diversity policy documents annual cultural diversity training requirements for Customer Operations, Marketing, and Medical Care Management staff.

Recommendation:
It is recommended that Optima revise the above policies to include procedures for evaluating the effectiveness of the interventions in promoting the delivery of services in a culturally competent manner to enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.

QA6. 438.208 Coordination and continuity of care.

Element 6.1 - MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.
This element is previously met - not reviewed.

QA7. 438.208(c) 1-3 Additional services for enrollees with special health care needs.

Element 7.1 - The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.
This element is previously met - not reviewed.

QA8. 438.208(c) (4) Direct access to specialists.

Element 8.1 - The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.
This element is previously met - not reviewed.

Element 8.2 Referral guidelines that demonstrate the conditions under which PCPs arrange for referrals to specialty care networks.
This element is previously met - not reviewed.

QA9. 438.208 (d) (2) (ii – iii) Referrals and treatment plans.

Element 9.1 - The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.
This element is previously met - not reviewed.

QA10. 438.208(e) Primary care and coordination program.

Element 10.1 - MCO coordinates services furnished to enrollee with those of other MCOs, PIHP, PAHP to prevent duplication.
This element is previously met - not reviewed.

Element 10.2 - Coordination of care across settings or transitions in care.
This element is previously met - not reviewed.

Element 10.3 - MCO has policies and procedures to protect enrollee privacy while coordinating care.
This element is previously met - not reviewed.

QA11. 438.210 (b) Coverage and authorization of services - processing of requests.

Element 11.1 - The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.
This element is previously met - not reviewed.

Element 11.2 - MCO has policies/procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventive services and basic prenatal care.
This element is met.

The Medical Care Management Operational Policy #2, Services Requiring Authorization and Timeframes for Decisions, includes preventive services under the listing of services not requiring pre-authorization in the February 2005 revision. This service was omitted from the prior version.

Element 11.3 - The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.
This element is partially met.

The Medical Care Management policy, Inter-rater Review MCM Staff, revised August 2003, includes mechanisms for monitoring the application of review criteria; however, the audit areas did not specifically request the auditor to evaluate the content of the pre-/concurrent/post-review record for accuracy and consistency in the staff's application of the medical review criteria. Each staff member is required to achieve a minimum score of 90% or require a developmental plan for correction of non-compliance. There does not appear to be a minimum goal for assessment of physician inter-rater reliability. Rather, the policy states that the Medical Director will review cases at the Medical Director's bi-weekly meeting to ensure decisions are being made fairly and consistently utilizing the medical criteria. Meeting minutes from the Medical Care Management Case Manager/Social Worker meeting of February 17, 2005 included an agenda item, education update, where answers to the test were discussed for the non-physician review staff. There was no specific mention of overall tests results or any planned follow-up. No documentation was available to support monitoring of physician review staff.

Recommendation:
It is recommended that Optima develop a more formalized process for assessing inter-rater reliability among its physician review staff, including minimum thresholds for performance and corrective action if indicated. There should be evidence of formal reporting of results for both physician and non-physician review staff to the appropriate committee on at least an annual basis.

Element 11.4 - The MCO has policies/procedures in place for staff to consult with requesting providers when appropriate.
This element is previously met - not reviewed.

Element 11.5 - If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.
This element is previously met - not reviewed.

Element 11.6 - Subcontractor's utilization management plan is submitted annually and upon revision.
This element is not met.

As evidence of compliance with this element, Optima submitted a newly created policy, Subcontractor Monitoring, which applies to the following vendors: Medical Transportation Management (MTM), Cole Managed Vision, and Doral Dental, USA. While procedures require maintenance of a review log for each vendor that includes utilization management program receipt/review date, there was no evidence that a utilization management plan had been submitted from the only vendor delegated UM activities. According to the Medicaid Program Manager there was no documentation available of formal Quality Improvement Committee (QIC) review or approval of the Doral Dental UM plan for 2004.

Recommendation:
In order to receive a finding of met; it is recommended that Optima provide copies of utilization management plans from each subcontractor delegated UM activities for the time frame reviewed, with evidence that an annual review of each utilization management plan was conducted by the appropriate committee.

Element 11.7 - The MCO has policies/procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
This element is previously met - not reviewed.

Element 11.8 - MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.
This element is previously met - not reviewed.

Element 11.9 - MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.
This element is met.

The Medical Care Management Operational Policy #2, Services Requiring Authorization and Timeframes for Decisions, includes language that Medical Care Management staff involved in decision making are not provided incentives for denying, limiting, or discontinuing services for enrollees. Proposed changes to the July 2005 revision of the enrollee handbook include adding language in the enrollee rights section that enrollees have the right to obtain information from the MCO on how providers are paid and includes the prohibition of incentives for denials, limiting, or discontinuing medical services. This right is also included in the Member Rights and Responsibilities policy, revised May 2005.

QA12. 438.210 (c) Coverage and authorization of services - notice of adverse action.

Element 12.1 - MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.
This element is previously met - not reviewed.

QA13. 438.210 (d) (1) Timeframe for decisions – standard authorization decisions.

Element 13.1 - MCO provides decision notice as expeditiously as enrollee's health condition requires, not exceeding 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.
This element is previously met - not reviewed.

QA14. 438.210 (d) (2) Timeframe for decisions – expedited authorization decisions.

Element 14.1 - The MCO has policies/procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three working days after receipt of the request for service.
This element is previously met - not reviewed.

Element 14.2 - The MCO has policies/procedures relating to the extension time frames for expedited authorizations allowed under the state contract.
This element is not met.

As noted in the 2003 review the policy, Services Requiring Authorization and Timeframes for Decisions, revised February 2005, did not contain extension time frames for expedited authorizations as allowed under the Medallion II contract. The Medallion II Managed Care Contract states that for expedited

authorizations "the Contractor may extend the three (3) working days turnaround time frame by up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies to the Department a need for additional information and how the extension is in the enrollee's interest."

Recommendation:
In order to receive a finding of met in the next review, Optima must revise the above policy to include the extension time frame for expedited authorizations provided in the Medallion II Managed Care Contract. A revised Services Requiring Authorization and Timeframes for Decisions policy was subsequently submitted and will be assessed for compliance in the next EQRO review.

QA15. 438.214 (b) Provider selection - credentialing and recredentialing requirements.

Element 15.1 - The MCO has written policies/procedures for selection and retention of providers using 2003 NCQA guidelines.
This element is previously met - not reviewed.

Element 15.2 - MCO recredentialing process takes into consideration the performance indicators obtained through quality improvement projects (QIPs), utilization management program, grievances and appeals, and enrollee satisfaction surveys.
This element is previously met - not reviewed.

Element 15.3 - MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.
This element is previously met - not reviewed.

QA16. 438.214 (c) Provider selection - nondiscrimination.

Element 16.1 - MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
This element is previously met - not reviewed.

QA17. 438.12 (a, b) Provider discrimination prohibited.

Element 17.1 - For those individual or group providers who are declined, the MCO provides written notice with reason for decision.
This element is previously met - not reviewed.

QA18. 438.214 (d) Provider Selection – excluded providers.

Element 18.1 - MCO has policies/procedures and adheres to ineligible provider or administrative entities requirements set forth in section K. Provider Relations.
This element is previously met - not reviewed.

QA19. 438.56 (b) Provider enrollment and disenrollment – requested by MCO.

Element 19.1 - MCO has policies/procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.
This element is previously met - not reviewed.

QA20. 438.56 (c) Provider enrollment and disenrollment – requested by enrollee.

Element 20.1 - MCO has policies/procedures in place for enrollees to request disenrollment.
This element is previously met - not reviewed.

Element 20.2 - MCO has policies/procedures and adheres to time frames established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).
This element is previously met - not reviewed.

QA21. 438.228 Grievance systems.

Element 21.1 - MCO has a process for tracking requests for covered services that were denied.
This element is previously met - not reviewed.

Element 21.2 - MCO has process for fair hearing notification.
This element is previously met - not reviewed.

Element 21.3 - MCO has process for provider notification.
This element is previously met - not reviewed.

Element 21.4 - MCO has process for enrollee notification and adheres to state time frames.
This element is previously met - not reviewed.

QA22. 438.230 Subcontractual relationships and delegation.

Element 22.1 - MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.
This element is previously met - not reviewed.

Element 22.2 - MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor.
This element is previously met - not reviewed.

Element 22.3 - MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
This element is previously met - not reviewed.

Element 22.4 - MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.
This element is previously met - not reviewed.

QA23. 438.236 (a, b) Practice guidelines.

Element 23.1 - The MCO has adopted practice guidelines that meet current NCQA standards and the following:

a) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
This component is previously met - not reviewed.

b) Consider the needs of the enrollees.
This component is previously met - not reviewed.

c) Are adopted in consultation with contracting health care professionals.
This component is previously met - not reviewed.

d) Are reviewed and updated periodically, as appropriate.
This component is previously met - not reviewed.

QA24. 438.236 (c) Dissemination of practice guidelines.

Element 24.1 - The MCO has policies/procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
This element is met.

The Member Rights and Responsibilities policy, revised May 2005, includes the right of enrollees to receive upon request a copy of the MCO's practice guidelines. This was not in evidence in the 2003 review. This element is now met with the inclusion of this language.

QA25. 438.236 (d) Application of practice guidelines.

Element 25.1 - MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.
This element is previously met - not reviewed.

QA26. 438.240 Quality assessment and performance improvement program.

Element 26.1 - MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.
This element is previously met - not reviewed.

Element 26.2 - MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.
This element is previously met - not reviewed.

Element 26.3 - The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.
This element is previously met - not reviewed.

QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services.

Element 27.1 - MCO's QAPI program has mechanisms to detect both underutilization and overutilization of the Medallion II services.
This element is previously met - not reviewed.

QA28. 438.240 (b) (3) Basic elements of QAPI program – care furnished to enrollees with special health needs.

Element 28.1 - MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.
This element is met.

The Optima Family Care Quality Improvement Program 2005 states as one of its objectives to "assess demographic and epidemiologic characteristics of the membership, including members with special needs or who are at risk for a chronic physical, developmental, behavioral, or emotional condition, and evaluate meaningful clinical and service monitors and activities including benchmarks". Attachment 3 of this document, Annual Work Plan CY 2005 identifies several activities directed at enrollees with special needs. For example, one of the activities addressed measuring the effectiveness of asthma disease management strategies and an asthma home health program on the management of adult and child enrollees with asthma. Specific tasks were identified, responsible parties, and completion goals.

QA29. 438.242 Health/management information systems.

Element 29.1 - The MCO has information systems capable of furnishing timely, accurate, and complete information about the Medallion II program.
This element is previously met - not reviewed.

Element 29.2 - The MCO information system is capable of meeting requirements.
This element is previously met - not reviewed.

Element 29.3 - Furnishing DMAS with timely, accurate and complete clinical and administrative information.
This element is previously met - not reviewed.

Element 29.4 - MCO ensures that data submitted by providers are accurate by meeting requirements.
This element is previously met - not reviewed.

Element 29.5 - MCO uses encryption processes to send PHI over the Internet.
This element is met.

The Optima Family Care Company-Wide policy, Secure Transmission of Clinical Data Over the Internet, states that it is permissible to use the Internet for transmission of clinical data as long as an acceptable method of encryption is utilized to provide for the confidentiality and integrity of the data, and that authentication or identification procedures are employed to ensure that both the sender and the recipient of the data know each other and are authorized to receive and decrypt such information. Detailed procedures for acceptable encryption methods are outlined.

Subpart F Regulations: Grievance Systems

GS1. 438.402 (a, b) Grievance system.

Element 1.1 - MCO has written policies and procedures that describe the grievance and appeals process and how it operates.
This element is previously met - not reviewed.

Element 1.2 - The definitions for grievances and appeals are consistent with those established by the state in July 2003.
This element is previously met - not reviewed.

Element 1.3 - Policies/procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the Medallion II program separately from the commercial program.
This element is previously met - not reviewed.

Element 1.4 - Policies/procedures describe how MCO responds to grievances and appeals in a timely manner.
This element is previously met - not reviewed.

Element 1.5 - Policies/procedures describe the documentation process and actions taken.
This element is previously met - not reviewed.

Element 1.6 - Policies/procedures describe the aggregation and analysis of the data and use in quality improvement.
This element is previously met - not reviewed.

Element 1.7 - The procedures and any changes to the policies/procedures must be submitted to the DMAS annually.
This element is previously met - not reviewed.

Element 1.8 - MCO provides information about the grievance and appeals system to all providers and subcontractors.
This element is partially met.

This element was partially met in the 2003 review as there was no evidence that Optima reviewed subcontractor policies and procedures for compliance with DMAS requirements for processing

grievances and appeals. This element continues to remain partially met in 2004 for the same reason. As evidence of compliance with this element, Optima submitted the Subcontractor Monitoring policy which states that Optima will review policies and procedures for vision, dental, and transportation subcontractors annually. While there is clearly a policy for review there must be evidence that the review occurs as documented in meeting minutes, a formal report, or correspondence to the subcontractors.

Recommendation:
In order to receive a finding of met in the next EQRO review, Optima should provide evidence of an annual review of all subcontractors' grievance and appeal policies and procedures to determine compliance with DMAS requirements as outlined in the contract modifications of July 2003. If they are determined to be out of compliance there should be evidence of a successful corrective action plan to bring them into compliance.

GS2. 438.402 (3) Filing requirements - procedures.

Element 2.1 - The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.
This element is previously met - not reviewed.

Element 2.2 - The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
This element is previously met - not reviewed.

GS3. 438.404 Notice of action.

Element 3.1 - Notice of action is written according to language and format requirements set forth in GS. 438.10 Information Requirements.
This element is partially met.

The notice of action is written in English; however, there is a sentence included in Spanish that advises enrollees that interpreter service is available in 140 languages but it does not explicitly state how to obtain this assistance. The notice does include a toll-free number for contacting Member Services to begin the appeals process. The notice of action does not contain any language that informs the enrollee that alternative formats are available for those with special needs, such as visual impairments or limited reading proficiency.

Recommendations:

In order to receive a finding of met in the next EQRO review, Optima needs to add language to the notice of action to describe how enrollees with special needs can obtain the information in alternative formats. A revised notice of action (NOA) was subsequently submitted and will be assessed for compliance in the next EQRO review.

GS4. 438.404 (b) Content of notice of action.

Content of NOA explains all of the following:

Element 4.1 - The action taken and reasons for the action.
This element is previously met - not reviewed.

Element 4.2 - The enrollee's right to file an appeal with MCO.
This element is previously met - not reviewed.

Element 4.3 - The enrollee's right to request a state fair hearing.
This element is previously met - not reviewed.

Element 4.4 - The procedures for exercising appeal rights.
This element is previously met - not reviewed.

Element 4.5 - The circumstances under which expedited resolution is available and how to request an expedited resolution.
This element is partially met.

The notice of action includes language advising enrollees that they have the right to request an expedited appeal, which must be communicated to Member Services. A toll-fee number is included for contacting Member Services. It does not include language describing the circumstances under which an expedited appeal is available.

Recommendation:

In order to receive a finding of met in the next EQRO review, Optima needs to add language to the notice of action to describe the circumstances under which an expedited appeal is available. A revised NOA was subsequently submitted and will be assessed for compliance in the next EQRO review.

Element 4.6 - The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.
This element is met.

In response to CY 2003 findings, Optima has added a denial code with a specific continuation of benefits message that will print on the notice of action letters. The language states that the enrollee has the right to continue the requested service during the appeal process and that if the appeal is denied the enrollee may be subject to pay for these services.

GS5. 438.416 Record keeping and reporting requirements.

Element 5.1 - The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.
This element is previously met - not reviewed.

GS6. 438.406 Handling of grievances and appeals – special requirements for appeals.

Element 6.1 - MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating enrollee's condition or disease.
This element is previously met - not reviewed.

Element 6.2 - MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.
This element is previously met - not reviewed.

Element 6.3 - MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.
This element is previously met - not reviewed.

Element 6.4 - MCO informs enrollee of limited time available for cases of expedited resolution.
This element is previously met - not reviewed.

Element 6.5 - MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.
This element is previously met - not reviewed.

Element 6.6 - MCO continues benefits while appeal or state fair hearing is pending.
This element is previously met - not reviewed.

GS7. 438.408 Resolution and notification: grievances and appeals – standard resolution.

Element 7.1 - MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires-not exceeding 30 days from initial date of receipt of the appeal.
This element is previously met - not reviewed.

Element 7.2 - In cases of appeal decisions not being rendered within 30 days, MCO provides written notice to enrollee.
This element is met.

The Member Services policy, Standard Appeals Procedures, was revised March 2005 and now includes required language that the MCO is responsible for sending written notification to the enrollee for any appeal decisions not rendered within 30 business days where the enrollee has not requested an extension. This correspondence extending the time frame up to an additional 14 calendar days must include the reason for the delay.

GS8. 438.408 Resolution and notification: grievances and appeals – expedited appeals.

Element 8.1 - MCO has an expedited appeal process.
This element is previously met - not reviewed.

Element 8.2 - The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three working days from the initial receipt of the appeal.
This element is previously met - not reviewed.

Element 8.3 - MCO has a process for extension, and for notifying enrollees of reason for delay.
This element is previously met - not reviewed.

Element 8.4 - MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.
This element is previously met - not reviewed.

GS9. 438.408 (b -d) Resolution and notification.

Element 9.1 - Decisions by the MCO to expedite appeals are in writing and include decision and date of decision.
This element is previously met - not reviewed.

Element 9.2 - For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a state fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.
This element is previously met - not reviewed.

Element 9.3 - MCO gives enrollee oral notice of denial and follow up within 2 calendar days with written notice.
This element is previously met - not reviewed.

GS10. 438.408 (c) Requirements for state fair hearings.

Element 10.1 - MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.
This element is previously met - not reviewed.

Element 10.2 - MCO provides state with a summary describing basis for denial and for appeal.
This element is previously met - not reviewed.

Element 10.3 - MCO faxes appeal summaries to state in expedited appeal cases.
This element is met.

The Member Services policy, Expedited Appeal Procedures, includes in its March 2005 revision procedures for faxing an appeal summary to DMAS and mailing to the enrollee as expeditiously as the

enrollee's health condition requires but no later than four business hours after DMAS informs the MCO of the expedited appeal.

GS11. 438.410 Expedited resolution of appeals, GS. 438.424 effectuation of reversed appeal resolutions.

Element 11.1 - The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or State Fair Hearing Department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.
This element is previously met - not reviewed.

Element 11.2 - MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.
This element is previously met - not reviewed.

Summary of Documents Reviewed		
Element	**Document**	**Date**
ER 1	OFC Policy: Member Rights and Responsibilities	05/2005 revised
	OFC Policy: Insolvency of MCO-Hold Harmless language	07/2005 effective
ER 3	OFC Policy: Interpreter and Translation Services	04/2005 effective
	Member Guide Changes for 7/2005 version	Undated
	Optima Family Care Member Guide	07/2004 revised
ER 5	MCM Policy #26: Emergency Care and Treatment	10/2004 revised
	Specialists: OFC and Stabilization	05/11/2005
	Optima Family Care Member Guide	07/2004 revised
ER 7	Silent (Call) Monitoring	03/05/2001 updated
	SFC Call Monitoring April 2005	Undated
	Sample monthly Member Service audit forms (completed)	04/18/2005, 04/25/2005
	Handling Protected Health Information (PHI)	11/17/2004 updated
	Policy 910: Voluntary Disclosure of Violations of Federal and State Laws and Regulations in a Timely Manner (copy of web page)	05/12/2005
	Policy 905: Employees' Responsibility for Compliance (copy of web page)	05/12/2005
	MCM Policy #11 Confidentiality	06/2004 reviewed
	SynQuest Technologies' Healthcare Education System- Employee Transcript Detail	07/18/2005
QA 1	MCM Operational Policy #15 Members Changing Benefit Plans and Continuity of Care	02/2005 revised
	Optima Family Care Member Guide	07/2004 revised
	Member Guide Changes for 7/2005 version	Undated
QA 5	OFC Policy: Cultural Diversity	05/2005 effective
	OFC Policy: Medical Intake Screenings	05/2005 revised
	OFC Policy: Interpreter and Translation Services	04/2004 effective
QA11	MCM Operational Policy #13 Inter-rater Review MCM Staff	08/2003 revised
	Medical Case Management Case Management Social Worker Meeting Minutes	02/17/2005
	OFC Policy: Subcontractor Monitoring	05/2005 effective
	MCM Operational Policy #2 Services Requiring Authorization and Timeframes for Decisions	02/2005 revised
	Optima Family Care Member Guide	07/2004 revised
	OFC Policy: Member Rights and Responsibilities	05/2005 revised
QA 14	MCM Operational Policy #2 Services Requiring Authorization and Timeframes for Decisions	02/2005 revised
QA 24	Optima Family Care Member Guide	07/2004 revised
	OFC Policy: Member Rights and Responsibilities	05/2005 revised
QA 28	Optima Family Care Quality Improvement Program 2005	Undated
QA 29	Optima Family Care Company-Wide Policy: Secure Transmission of Clinical Data Over the Internet	01/2001 revised
GS 1	OFC Policy: Subcontractor Monitoring	05/2005 effective
GS 3	OFC Policy: Interpreter and Translation Services	04/2005 effective
GS 4	Denial Reasons	05/01/2005 revised
	Medical Care Management Member Denial Letter	Undated
GS 7	Member Services Policy: Standard Appeals Procedures	03/2005 revised
GS 10	Member Services Policy: Expedited Appeal Procedure	03/2005 revised